STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

Francisco Buen III, MD,
Petitioner

v

Case No. 11-852-BC
Docket No. 2011-1598

Blue Cross Blue Shield of Michigan,
Respondent

Issued and entered
this 25th day of June 2012
by R. Kevin Clinton
Commissioner

FINAL DECISION

I. BACKGROUND

This case concerns an audit by Blue Cross Blue Shield of Michigan (BCBSM) of one of its participating providers, Dr. Francisco Buen III. Based on its audit findings, BCBSM concluded it had overpaid Dr. Buen $223,649.49 during the audit period of March 1, 2002 through August 31, 2003.

Dr. Buen disputed BCBSM's findings. A Review and Determination proceeding was held by the Commissioner's designee[1] who concluded that BCBSM was not entitled to recover the funds in question because BCBSM's recovery efforts occurred beyond the two year limitation for such efforts which is imposed by the Participation Agreement between the Petitioner and BCBSM. The Commissioner's designee also concluded that BCBSM had violated section 402(1)(l) of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), MCL 550.1402(1)(l) by failing to promptly provide a reasonable explanation of the basis for its denial of the claims BCBSM sought to recover from the Petitioner.

The findings in the Review and Determination were appealed to the Commissioner by BCBSM. A contested case hearing was scheduled. Prior to the hearing, the Petitioner filed a motion for summary decision. BCBSM filed a response and oral argument was held on the motion on January 9, 2012.

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1. See MCL 550.1404.

The administrative law judge (ALJ) issued a Proposal for Decision (PFD) on April 18, 2012. In the PFD, the administrative law judge recommended that the Commissioner (1) grant the Petitioner's motion for summary decision; (2) adopt the August 31, 2011 Review and Determination; (3) issue a final order that BCBSM is not entitled to pursue recovery from the Petitioner of any alleged overpayments; and (4) order that the contested case hearing scheduled for July 3, 2012, be cancelled.

Neither party has filed exceptions to the PFD. Michigan courts have long recognized that the failure to file exceptions constitutes a waiver of any objections not raised. *Attorney General v. Public Service Comm* 136 Mich App 52 (1984).

II. FINDINGS OF FACT

The findings of fact in the PFD are adopted. The PFD is attached and made part of this final decision.

III. CONCLUSIONS OF LAW

The conclusions of law stated in the PFD regarding BCBSM's ability to recover alleged overpayments in 2002 and 2003 are properly grounded in the facts of this case and are soundly reasoned. Those findings are adopted. BCBSM is barred by the audit time limits in the Participation Agreement from recovering funds paid to the Petitioner in 2002 and 2003.

The Review and Determination concluded that BCBSM had violated section 402(1)(l) of Act 350 and Administrative Rule 550.102(4).

Section 402(1)(l) of Act 350, MCL 550.1402(1)(l), provides:

> (1) A health care corporation shall not do any of the following:
>
> * * *
>
> (l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

Administrative Rule 550.102(4), 1986 AACS, R 550.102(4), provides:

> At the time of a refusal to pay a claim, the health care corporation shall provide in writing to the member and, if the claim was made by a provider, to the provider, a clear, concise, and specific explanation of all the reasons for

> the refusal. This notice shall notify the member or provider of the member's or provider's right to request a private informal managerial-level conference if the member or provider believes the refusal to be in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws.

The PFD did not conclude – and did not recommend that the Commissioner find – that BCBSM had violated Act 350. The ALJ is correct that BCBSM waited too long to assert a claim of fraud against the Petitioners. However, making an untimely legal argument does not constitute a prohibited practice under section 402 of Act 350, nor is it a violation of administrative rule R550.102(4). The Commissioner finds that BCBSM's conduct in pursuing the audit did not violate any provision of Act 350.

IV. ORDER

It is ordered that BCBSM may not recover the funds it sought from the Petitioner.

R. Kevin Clinton
Commissioner

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

In the matter of	Docket No.	2011-1598
	Agency No.	11-852-BC
Francisco Buen III, M.D., Petitioner	Agency:	Office of Financial & Insurance Regulation
v		
Blue Cross Blue Shield of Michigan, Respondent	Case Type:	Appeal Subscriber/Provider
_____/		

Issued and entered
this 18th day of April 2012
by Lauren G. Van Steel
Administrative Law Judge

PROPOSAL FOR DECISION TO GRANT PETITIONER'S MOTION FOR SUMMARY DECISION

PROCEDURAL HISTORY

Appearances: Gregory M. Nowakowski and Theresamarie Mantese, Attorneys at Law, appeared on behalf of Francisco Buen III, M.D., Petitioner. Bryant Greene, Attorney at Law, appeared on behalf of Blue Cross Blue Shield of Michigan, Respondent.

This matter concerns Respondent's petition for contested case hearing under Section 404 of the Nonprofit Health Care Corporation Act, 1980 PA 350, as amended, MCL 550.1101 *et seq.* (hereafter "Nonprofit Act") regarding its request for refund of alleged overpayments to Petitioner. The parties exhausted their rights to administrative review under 1986 AACS, R 550.101-108.

On August 31, 2011, the Commissioner's Designee issued a Review and Determination, finding that Respondent had violated Section 402(1)(l) of the Nonprofit Act and was not entitled to pursue a refund from Petitioner with respect to this audit dispute.

On October 31, 2011, Respondent submitted a petition for contested case hearing. On November 8, 2011, the Special Deputy Commissioner issued an Order Referring Complaint for Hearing and Order to Respond, with attached Complaint. On November 9, 2011, the agency filed a request for hearing with the Michigan Administrative Hearing System. On November 21, 2011, a Notice of Hearing was issued, which scheduled a contested case hearing for January 9, 2012.

On November 28, 2011, Petitioner filed Francisco Buen, M.D.'s Motion for Summary Disposition Affirming the Review and Determination and Brief, and requested oral argument. On November 29, 2011, Petitioner requested that a prehearing conference be scheduled. On November 30, 2011, Respondent filed Blue Cross Blue Shield of Michigan's Opposition to Petitioner's Motion for Summary Disposition. On November 30, 2011, the undersigned issued an Order Adjourning Hearing and Order Scheduling Prehearing Conference and Motion Hearing.

On January 9, 2012, the motion hearing and prehearing conference were held as scheduled. At the conclusion of the motion hearing, the undersigned took Petitioner's motion for summary decision under advisement. On January 12, 2012, the undersigned issued an Order Following Prehearing Conference that scheduled the contested case hearing for April 11 and 12, 2012.

On March 13, 2012, Petitioner filed Petitioner's Supplemental Authority to Motion for Summary Disposition, including a transcript of the January 9, 2012 motion hearing (hereafter "1/9/12 Tr").

On March 22, 2012, the parties filed a stipulation to adjourn the contested case hearing. On March 28, 2012, the undersigned issued an Order Granting Adjournment, rescheduling the contested case hearing to July 3, 2012.

Petitioner's motion for summary decision is now appropriately addressed under Rule 11(c) of the administrative rules for the Office of Financial and Insurance Regulation hearing procedures, being 1983 AACS, R 500.2111(c).

ISSUES AND APPLICABLE LAW

The underlying issue is whether Respondent is entitled under the Nonprofit Act, *supra*, to a refund for the alleged overpayments. Respondent now seeks a refund from Petitioner in the total amount of $223,649.49 based on a post-payment audit period of March 1, 2002 through August 31, 2003.

The dispositive issue presented by Petitioner's motion for summary decision under 1983 AACS, R 500.2111(c) is whether any genuine issue as to material fact exists such that Petitioner is entitled to a decision in his favor based on Respondent not being entitled to seek recovery as a matter of law.

The Order Referring Complaint for Hearing, dated November 8, 2011, cites the following subsections of Section 402(1) of the Nonprofit Act, *supra*:

> (1) A health care corporation shall not do any of the following:
>
> * * *
>
> (c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

> (d) Refuse to pay claims without conducting a reasonable investigation of a claim arising under a certificate.
>
> (e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.
>
> (f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.
>
> * * *
>
> (l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement. MCL 402(1)(c)-(f) & (l). (Emphasis supplied).

In addition, Rule 102(4) of the administrative rules pertaining to Nonprofit Act, *supra*, procedures before the Commissioner states as follows:

> Rule 102. (4) At the time of a refusal to pay a claim, the health care corporation shall provide in writing to the member and, if the claim was made by a provider, to the provider, a clear, concise, and specific explanation of all the reasons for the refusal. This notice shall notify the member or provider of the member's or provider's right to request a private informal managerial-level conference if the member or provider believes the refusal to be in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws. 1986 AACS, R 550.102(4). (Emphasis supplied).

FINDINGS OF FACT

Based on the record as a whole, the following findings of fact are established:

1. Addendum H to the parties' Participation Agreement provides in relevant part:

> BCBSM [Respondent herein] shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary as determined by BCBSM under Addendum 'A'. * * *
>
> BCBSM shall have the right to initiate recovery of amounts paid for services up to two (2) years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries. ["Exhibit B" to Petition for Contested Case Hearing, p 19. (Emphasis supplied)].

2. In September 2003, Respondent commenced an audit of Petitioner's medical records (Audit #2003300774). In December 2003, Respondent commenced another audit of Petitioner's medical records (Audit #200301820). Taken together, the two audits examined Petitioner's services from March 1, 2002 through August 31, 2003. [Petition for Contested Case Hearing, p 2].

3. On May 19, 2004, Respondent sent Petitioner correspondence containing initial audit findings. This correspondence did not include any determination of fraud on Petitioner's part. The initial audit findings referred to a "minimum total overpayment amount of $267,486.69", but did not state an actual refund request at that time. Respondent has acknowledged that the May 19, 2004 correspondence was in the nature of preliminary findings that did not notify Petitioner of his appeal rights and did not indicate that recovery was being initiated. [5/19/04 letter (Attachment "D" to Motion for Summary Disposition); 1/9/12 Tr, pp 17-18].

4. Respondent did not initiate its request for recovery within two years from the date of payment for the audit period of March 1, 2002 through August 31, 2003.

5. Respondent likely referred its initial audit findings to an internal review unit and to law enforcement for possible fraud, but no findings of fraud were made by the review unit or law enforcement. [1/9/12 Tr, pp 24-25; "Exhibit C" to Petition for Contested Case Hearing].

6. By letter of January 22, 2008, Respondent notified Petitioner that it had completed its internal review and that its investigation had "revealed no information that would support additional changes in the final audit findings." [1/22/08 letter (Attachment "E" to Motion for Summary Disposition)].

7. Through written notices to Petitioner on January 22, 2008 and April 2, 2008, Respondent reduced the amount of its refund request to a total of $252,589.24, eliminating the portion for services paid from March 1, 2002 through May 19, 2002, as being beyond the two-year recovery period. Respondent limited its request for recovery to services paid between May 20, 2002 and August 31, 2003. [1/22/08 and 4/2/08 letters (Attachments "E" & "H" to Motion for Summary Disposition); 1/9/12 Tr, p 23].

8. On June 3, 2008, Respondent referenced the two-year recovery period at the Managerial Level Conference, and reduced its overpayment demand from $252,589.24 to $223,649.49. [6/3/08 & 11/21/08 letters (Attachments "J" & "L" to Motion for Summary Disposition)].

9. By foregoing recovery for the period of March 1, 2002 through May 19, 2002, Respondent in effect acknowledged that the terms of the Participation Agreement required it to initiate recovery within two years of the date of payment except in instances of fraud. Respondent stated in its position

paper at the Review and Determination level, "If there is no fraud, BCBSM can only audit claims up to two (2) years from the date of payment." ["Exhibit C" to Petition for Contested Case Hearing, p 2].

10. If Respondent had been relying upon the "fraud" exception in the Participation Agreement "as to which there will be no time limit on recoveries", it would not have had reason to reduce its request for refund for the period of March 1, 2002 through May 19, 2002 to reflect the two-year recovery period in Addendum H to the Participation Agreement. ["Exhibit B" to Petition for Contested Case Hearing, p 19].

11. On August 28, 2008, a Managerial Level Conference was held and additional documentation submitted. After this conference, Respondent's consultant approved some services that had been initially denied. The consultant further found that the additional documentation was insufficient to allow a determination of medical necessity. The consultant specifically noted that there was a lack of signatures on daily notes, written discharge notes and PT evaluations in Petitioner's patient records. As a result of the conference, Respondent's total refund request was revised to an extrapolated amount of $223,649.49. [11/21/08 letter (Attachment "L" to Motion for Summary Disposition)].

12. In Respondent's initial request for refund and correspondence to Petitioner after the Managerial Level Conference, it did not allege anything more than that Petitioner had failed to follow the guidelines that he had a contractual obligation to follow in submitting claims. Respondent's basis for seeking refund concerned improper billing and audit findings that documentation did not meet payment requirements or did not contain sufficient findings to substantiate the need for certain procedures. Petitioner likely detrimentally relied upon Respondent's explanation for seeking refund at this stage of the administrative process. [1/22/08, 4/2/08 & 11/21/08 letters (Attachments "E", "H" & "L" to Motion for Summary Disposition); "Exhibit D" to Petition for Contested Case Hearing].

13. In this matter, Respondent first relied upon the "fraud" exception to the Participation Agreement in its position paper of August 1, 2011, directed to the Commissioner's Designee. It then made a specific allegation of fraud against Petitioner, based on an asserted "pattern of consistently over billing," in its Petition for Contested Case Hearing that it filed with the Office of Financial and Insurance Regulation on October 31, 2011. ["Exhibit C" to Petition, and Petition, p 4].

14. Prior to the Review and Determination stage of the administrative process, Respondent did not make any allegations that would likely meet the definition of "fraud" and/or the knowing submission of false claims. See Respondent's Response, pp 2-6.

CONCLUSIONS OF LAW

Petitioner has now moved for summary decision under Rule 11(c), which provides as follows:

> Rule 11. A party may move for a summary decision in the party's favor upon any one of the following grounds: * * *
>
> (c) There is no genuine issue as to any material fact and the moving party is therefore entitled to a decision in that party's favor as a matter of law. 1983 AACS, R 500.2111(c).

This procedural rule has been recognized in case law as a valid means of resolution for administrative proceedings before the Commissioner. *American Community Mut. Ins. Co. v Commissioner of Insurance*, 195 Mich App 351; 491 NW2d 597 (1992).

Here, Petitioner contends that Respondent's appeal should be dismissed as a matter of law for three reasons: 1) that Respondent is time-barred from claiming the fraud exception to the Participation Agreement under the six-year statute of limitations; 2) that Respondent's claim of fraud violates or is contrary to the notice and fairness requirements in Sections 402(1)(f) and (l) of the Nonprofit Act, *supra*; and 3) that the Commissioner's Designee made no finding of fraud and Respondent's fraud unit never made such finding after eight years of the appeal process. (Petitioner's Brief Supporting Summary Disposition, pp 1-2 & 8).

As to the first reason given, Petitioner has shown that Respondent is time-barred from seeking recovery under the terms of the Participation Agreement because Respondent initiated recovery more than two years after the date of payment and the fraud exception does not apply. As set forth in the findings of fact above, Respondent now seeks to recover amounts paid for services from May 20, 2002 and August 31, 2003, but it did not initiate recovery until January 22, 2008. Except for instances of fraud, Respondent has the right to initiate recovery only up to two years from the date of payment under the terms of the Participation Agreement. Respondent did not initiate its request for recovery within two years of the date of payment, and as discussed further below, Petitioner has not shown that the fraud exception to the Participation Agreement applies.

Petitioner has not clearly shown that the six-year statute of limitations in MCL 600.5813 for civil causes of action would apply to the present administrative proceeding before the Commissioner under the Nonprofit Act, *supra.* In *Latreille v Michigan Board of Chiropractic Examiners*, 257 Mich 440; 98 NW2d 611 (1959), the Michigan Supreme Court held that a statute of limitation should not be applied by analogy to an administrative proceeding brought to protect the public. Petitioner has not shown any provision in the Nonprofit Act (or in the Act's legislative history) that would expressly limit the period of recovery. Nor has Respondent shown authority for its argument that the Participation Agreement would act to toll the statute of limitation if otherwise applicable. (Respondent's Response, p 8). Tolling provisions are to be applied

according to specific terms in the underlying statute. *Bates v Mercier*, 224 Mich App 122; 568 NW2d 362 (1997). The only private right of action authorized by the Nonprofit Act is an action by a subscriber against the health care corporation for damages. *BPS Clinical Laboratories v Blue Cross and Blue Shield of Michigan*, 217 Mich App 687; 552 NW2d 919 (1996), appeal denied 456 Mich 881; 570 NW2d 782.

Further, Petitioner has not shown that summary decision is properly granted based on the Commissioner Designee's findings alone. As the Special Deputy Commissioner has stated in another matter, "A review and determination is an informal adjudication of audit disputes which may be appealed by either party. The findings of a review and determination are not binding on an ALJ or the Commissioner." (Order Regarding Interlocutory Appeal, dated September 29, 2011 in Case No. 10-799-BC; Docket No. 2011-15).

Petitioner has sufficiently shown that Respondent's reliance upon the "fraud" exception at this point in the administrative process is contrary to Section 402(1)(l) of the Nonprofit Act, *supra*. As found above, Respondent did not assert allegations of fraud throughout the administrative process up to the filing of its Petition for Contested Case Hearing. Petitioner likely detrimentally relied upon Respondent's explanation for seeking refund prior to the Review and Determination level. As such, Respondent failed to provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement. To assert fraud now without any adequate explanation is contrary to Section 402(1)(l) of the Nonprofit Act, *supra*.

Rule 102(4) also requires a health care corporation to provide a "clear, concise, and specific explanation of all the reasons for the refusal". 1986 AACS, R 550.102(4). Although the instant matter involves a request for refund, as opposed to a refusal in the first instance, the sample principle would appear to apply throughout the administrative review process.

Petitioner has not shown, however, that Respondent's actions would necessarily violate Section 402(1)(f) of the Nonprofit Act, *supra*, where payment or "settlement" for the claims at issue has already been made and refund is sought.

Respondent has not contested Petitioner's assertion that Respondent's own internal fraud unit and law enforcement never made any finding of fraud after eight years of the appeal process. Prior to the Review and Determination level, Respondent did not make any specific allegation of fraud. [1/9/12 Tr, pp 19-21]. A claim of fraud raised only by vague inference does not satisfy the law. A vague inference alone is not a "reasonable explanation" under MCL 550.1402(1)(l). Respondent, as the nonmoving party to the motion for summary decision, has not produced an affidavit or other documentary evidence to establish that there is a genuine issue of material fact. *Star Steel Supply Co v United States Fidelity & Guaranty Co.*, 186 Mich App 475, 480; 465 NW2d 17 (1990); *American Community Mut. Ins. Co. v Commissioner of Insurance*, *supra* at 363. See also, MCR 2.116(G)(4). Therefore, it is concluded that no genuine issue of material fact exists and Petitioner is entitled to summary decision as a matter of law under MCL 550.1402(1)(l) and 1986 AACS, R 550.102(4).

PROPOSED DECISION

Based on the above, the following decision is proposed to the Commissioner:

1. That Petitioner's motion for summary decision be granted under Rule 11(c) on the grounds that no genuine issue of material fact exists and Petitioner is entitled to a decision in his favor as a matter of law under the terms of the parties' Participation Agreement, MCL 550.1402(1)(l) and 1986 AACS, R 550.102(4);

2. That the Commissioner Designee's Review and Determination of August 31, 2011, be adopted in the Commissioner's Final Order;

3. That the Commissioner's Final Order determine that Respondent is not entitled to pursue recovery from Petitioner of the alleged overpayments for the audit period at issue; and

4. That the contested case hearing currently scheduled in this matter for July 3, 2012, be cancelled.

EXCEPTIONS

Any Exceptions to this Proposal for Decision should be filed in writing with the Office of Financial and Insurance Regulation, Division of Insurance, Attention: Dawn Kobus, P.O. Box 30220, Lansing, Michigan 48909, within twenty (20) days of the issuance of this Proposal for Decision. An opposing party may file a response within ten (10) days after Exceptions are filed.

Lauren G. Van Steel
Administrative Law Judge